MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00308

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 29 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 months, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Frederick
City or town Frederick (If outside city or town limits, write RURAL and give nearest town)
Street No. Seventh Street (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Walter Rice Abrecht

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret E. Abrecht
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 12, 1903

8. AGE: Years	Months	Days	If less than one day
41	2	20	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Paperhanger and painter
11. Industry or business

FATHER
12. Name: Niles Abrecht
13. Birthplace: Md.

MOTHER
14. Maiden name: Josephine ?
15. Birthplace: Md.

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-1945 (month) (day) (year)
Cemetery or crematory: Lewistown Meth. Cemetery
Location: Lewistown - Md.
18. Funeral director: C. E. Cline and Son
Address: Frederick - Md.

19. Jan. 2 1945 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 1945 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3 1944 to Jan. 2 1945 and that I last saw him alive on Jan 1 1945

Immediate cause of death	DURATION
General Paresis	14 yrs.
Due to	
Due to	
Other conditions	

Psychosis c syphilitic meningoencephalitis
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results: As above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward J. Kerman M. D. or other
Address: Sykesville, Md. Date signed 1-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-A

00309

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville Rural Oklahoma
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Carroll

City or town: Sykesville Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Oklahoma
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Catherine Amelia Alexander

3.(b) Social Security Number 4

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: John Theodore Alexander

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1849

8. AGE:

Years	Months	Days	If less than one day
95	3	19	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Belt
13. Birthplace: Unk—

MOTHER
14. Maiden name: Susanna Ward
15. Birthplace: Md.

16. Informant: Mrs. Virginia C. Leatherwood
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 15 1945 (month) (day) (year)

Cemetery or crematory: Wards Chapel Cem.

Location: Liberty road, Balto Co. Md.

18. Funeral director: C. Harry Weber

Address: Sykesville, Md.

19. Jan. 13 1945 (Date rec'd by registrar) C. Harry Weber Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1945 at 8:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1940, to Jan. 12, 1945 and that I last saw h— alive on Jan 11, 1945

Immediate cause of death	DURATION
Cardio-vascular Dis.	5
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jno. E. Martin M. D. or other

Address: Randallstown Md Date signed 1/13/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

00310 (71)

1. PLACE OF DEATH 157

County Carroll Registration Dist. No. 74

Village or City Westminster No. RD #7 Tyson St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 hr ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Baby Boy Baker If U.S. Veteran specify WAR ...

(a) Residence: No. RD #7 Westminster St., Ward ...

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Jan 23/45

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1 hr			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Westminster RD #7
(State or country)

FATHER

13. NAME Stanley Baker

14. BIRTHPLACE (city or town) Caroline Co
(State or country) Md.

MOTHER

15. MAIDEN NAME Melvin

16. BIRTHPLACE (city or town) Caroline Co Md.
(State or country)

17. INFORMANT Stanley Baker
(Address) Westminster Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Home place Date Jan 24, 1945

19. UNDERTAKER C. O. Fuss & Son
(Address) Taneytown Md.

20. FILED Jan 24, 1945 Margaret R. England
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 23, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1945, to Jan 23, 1945
I last saw h[illegible] alive on Jan 23, 1945; death is said
to have occurred on the date stated above, at 3:00 P m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Premature	
Other Contributory Causes of importance: difficult labor	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) W. Glenn Gaugher M. D.

(Address) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, **not** the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

00311 Reg. Dist. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Taneytown Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME L. Edna B. Baumgardner

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife Andrew J. Baumgardner

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1880

8. AGE:	Years	Months	Days	If less than one day
	64	7	3	hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

MOTHER 12. Name Matilda E. Zeneszer

MOTHER 13. Birthplace Md

FATHER 14. Maiden name

FATHER 15. Birthplace

16. Informant Mervin E. Wantz

Address Taneytown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18, 1945 (month) (day) (year)

Cemetery or crematory Reformed

Location Taneytown Md

18. Funeral director C. O. Bussard Son

Address Taneytown Md

19. Jan 17. 1945 (Date rec'd by registrar) Ethel M. Mehring Local Registrar

MEDICAL CERTIFICATION

Person to

20. DATE OF DEATH January 15 1945, at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension arteriosclerosis C-V disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Marsh, Deputy Medical Examiner M. D. or other

Address New Windsor Md Date signed 1/15/45

Evidence for change of date of birth is shown on FILM No. G 92 MAR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

00312

Reg. Dist. No. 82

1. PLACE OF DEATH

County: Carroll

City or town: Rural - Mt. Airy.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural - Mt. Airy.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Mt. Airy. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Geraldine Bennett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1944

8. AGE: Years | Months: 4 | Days: 3.7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: James Bennett

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Beatrice Anderson

15. Birthplace: Maryland

16. Informant: Mr. James Bennett

Address: Mt. Airy. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-45 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Near Mt. Airy. Carroll Co. Md.

18. Funeral director: C. M. Wallz

Address: Winfield Md.

19. Jan 20 1945 (Date rec'd by registrar) H. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1945 to Jan 19 1945 and that I last saw h[illegible] alive on Jan 17 1945

Immediate cause of death	DURATION
Broncho-pneumonia	7 days
Due to: Acute bronchitis	2 wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Ernest P. Roop, M.D. M. D. or other

Address: New Market Md Date signed: Jan 19 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00313

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 6 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Saverna Park
(If ontside city or towu limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MAMIE JEFFRIES BETTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	3	hrs. min.

9. Birthplace: Earleigh Heights, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Louis Jeffries
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Anna Jones
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 (month) 8 (day) 45 (year)
Cemetery or crematory: Early Heights
Location: Earlyheights Md.
18. Funeral director: Albert L. Hicks
Address: H5 Northumberland Ave Balto Md.

19. Jan. 5, 1945 (Date rec'd by registrar) Albert L. Hicks Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5, 1945, at 5:10A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 30, 1944, to Jan. 5, 1945 and that I last saw h...er alive on January 5, 1945.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed 1-5-45

M

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-21)

CERTIFICATE OF DEATH

00314

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Manchesterville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Manchesterville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Blinkey

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 12, 1870

8. AGE:

Years	Months	Days	If less than one day
74	1	22	..... hrs. ..... min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER

12. Name: Gottlieb Blinkey

13. Birthplace: Russia

MOTHER

14. Maiden name: Louise — ?

15. Birthplace: Russia

18. Informant: Mrs. Louise Caddew

Address: 1514 E. Fort Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5 1945 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Taylorsville Md.

18. Funeral director: C. Harry Ebert

Address: Taylorsville, Md.

19. Jan. 4 1945 C. Harry Ebert

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942, to 1945

and that I last saw h... alive on Jan. 1 at 1945

Immediate cause of death	DURATION
Cardio-vascular Disease	
Due to Arteriosclerosis	
Due to	
Other conditions Valvular Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jno. E. Martin M. D. or other

Address: Randallstown Date signed 1/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

00315

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Finksburg (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Finksburg - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Etta Bond

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife -
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 8 - 1885

8. AGE: Years 59 | Months 7 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Benjamin F. Bond
13. Birthplace Maryland

MOTHER 14. Maiden name Emma J. Roop
15. Birthplace Maryland

16. Informant Benjamin Bond
Address Finksburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26/45 (month) (day) (year)

Cemetery or crematory Emory
Location Owings Mills Md

18. Funeral director Edw. C. Tipton
Address Hampstead Md

19. 1-26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 1945 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to Jan. 22 1945 and that I last saw her alive on Jan. 21 1945

Immediate cause of death	DURATION
Cyst-nephritis	1 mo
Due to Multiple Sclerosis	10 years
Due to	
Other conditions Fracture of R hip	4 mo.

Accidental fall; slipped on wet porch.
(Include pregnancy within 3 months of death) C.W.G.

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of Oct. 20, 1944
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Accidental fall. Injured at work?

23. SIGNATURE Maurice C. Partenfield M. D. or other
Address Sampsville, Md Date signed 1-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

00316

CERTIFICATE OF DEATH

Reg. Diat. No. 79

1. PLACE OF DEATH:
County: Carroll
City or town: Rural, Near Key-mar.
(If ontside city of town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For uewborn infants give residence of mother)
State: Md. County: Carroll
City or town: Rural
(If outside city or town limits, write RURAL aud give nearest town)
Street No.: Near Key-mar,
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emily Jane Bowers.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1859 - Nov. 23 - 1945

8. AGE: Years	Months	Days	If less than one day
85	1	2	hrs. min.

9. Birthplace: Woodsboro, Md. (Town, county, and state)
10. Usual occupation: Seamstress,
11. Industry or business

FATHER
12. Name: Allen J. Bowers
13. Birthplace: Md.

MOTHER
14. Maiden name: Clementine Virginia Hoff
15. Birthplace: Md.

16. Informant: Mrs. Frank Bleasing
Address: Key-mar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-45 (month) (day) (year)
Cemetery or crematory: Mt. Hope Cemetery
Location: Woodsboro, Md.

18. Funeral director: C. O. Fuss & Son
Address: Taneytown, Md.

19. Jan. 27 1945 (Date rec'd by registrar) Mrs Emma Fuss. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25 - 1945, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. - 1940, to Jan. 25 - 1945 - and that I last saw her alive on Jan. 24 1945

Immediate cause of death	DURATION
Heart Failure	2 days
Due to La Grippe	2 wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: Jas. H. Beall, M.D.
M. D. or other
Address: Libertytown Date signed 1-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

00317

Reg. Diat. No. 70

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Samuel Boyd

3. (b) Social Security Number 218-07-8304

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Alice M. Shorb

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 26, 1877

8. AGE:

Years	Months	Days	If less than one day
67	4	18	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER

12. Name: Nelson Boyd

13. Birthplace: Maryland

MOTHER

14. Maiden name: Babylla

15. Birthplace: Maryland

16. Informant: Mrs. Samuel Boyd

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 17 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C. O. Sauss & Son

Address: Taneytown, Md.

19. Jan 17 1945 (Date rec'd by registrar) Ethele M. Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14th 1945, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19th 1944, to Jan 14th 1945 and that I last saw him alive on Jan 13th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Dec 19th 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. M. Benner M.D. M. D. or other

Address: Tanneytown Md Date signed 1/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00318

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 917 McCulloh St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN BREADMON

3.(b) Social Security Number: 217-22-8730

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1926

8. AGE: Years	Months	Days	If less than one day
18	2	15	hrs. min.

9. Birthplace: St. George, S.C. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business
FATHER 12. Name: Milton Breadmon
13. Birthplace: Unknown
MOTHER 14. Maiden name: Anna Kibbets
15. Birthplace: Unknown
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 30 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Annapolis Road.
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill ave
19. Jan. 25, 19 45 (Date rec'd by registrar) Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1945 at 8:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1944 to Jan. 25, 1945 and that I last saw him alive on Jan. 25, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 1-25-45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(T)

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00319

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 28 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin, R.F.D. #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MAGGIE BRIDDELL

3.(b) Social Security Number: 219-03-2065

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12, 1903

8. AGE: Years	Months	Days	If less than one day
41	10	3	hrs. min.

9. Birthplace: Berlin, Md. (Town, county, and state)
10. Usual occupation: Factory Worker
11. Industry or business

FATHER
12. Name: Thomas Lookwood
13. Birthplace: Unknown

MOTHER
14. Maiden name: Jennie Bowen
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18 1945 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Salisbury Md.

18. Funeral director: D. W. Chase and Son
Address: 638 n. Gilmore St.

19. Jan. 15, 19 45 (Date rec'd by registrar) Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: January 15, 1945, at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18, 1944, to Jan. 15, 1945
and that I last saw her alive on January 15, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 00320 96

1. PLACE OF DEATH:
County Carroll
City or town Patapsico
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Patapsco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Matilda Brown

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Noah Brown
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 1872

8. AGE: Years	Months	Days	If less than one day
72	10		hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name William Flater
13. Birthplace Md.

MOTHER
14. Maiden name Martha Bloom
15. Birthplace Md.

16. Informant Marshall Flater
Address Patapsco, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan. 7th 1945 (month) (day) (year)
Cemetery or crematory Pleasant Grove
Location Sandymount Carroll Co. Md.
18. Funeral director H Bankard & Sons
Address Westminster, Md.
19. 1/6 (Date rec'd by registrar) 19 45 H K Unverdruss Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5 19 45 at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/3 19 45, to 1/5 19 45
and that I last saw h Ea alive on 1/5 19 45

Immediate cause of death	DURATION
Acute Cerebral Hemorrhage	36 hrs.
Due to Chr. Colitis - Adhesions	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lucile Bair (MD) M. D. or other
Address Westminster Maryland Date signed 1/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00321

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster (If outside city or town limits, write RURAL and give nearest town)

Street No. 44 Main Street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ellen Carr

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: William Thomas Carr

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 14 - 1875

8. AGE:

Years	Months	Days	If less than one day
69	11	5	..... hrs. ..... min.

8. Birthplace: Carroll Co. Md. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: Samuel Carr

13. Birthplace: Maryland

MOTHER

14. Maiden name: Catherine Smith

15. Birthplace: Maryland

16. Informant: Mary E. White

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 22 - 1945 (month) (day) (year)

Cemetery or crematory: Warfieldsburg Cemetery

Location: Warfieldsburg Md.

18. Funeral director: H B Bankard Son

Address: Westminster, Md.

19. 1/20 19 45 — G Woodward Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 3-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 30 1941 to 1-18-1945 and that I last saw her alive on Jan 18 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	5 days
Due to: arteriosclerosis	indefinite
Due to:	
Other conditions: Myocarditis	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E Reese Wolbert M. D. or other

Address: Westminster Md. Date signed 1/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00322

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 30 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
JAMES WESLEY COATES

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Venie Coates
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): August 15, 1871

8. AGE:

Years	Months	Days	If less than one day
73	5	7	hrs. min.

9. Birthplace: Lower Marlboro, Md.
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business
FATHER 12. Name: Isaac Coates
13. Birthplace: Lower Marlboro, Md.
MOTHER 14. Maiden name: Mandie Johnson
15. Birthplace: Lower Marlboro, Md.
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/45 (month) (day) (year)
Cemetery or crematory: Bacon Cemetery
Location: Bacon near Laurel, Md.
18. Funeral director: Ridgley & Selby
Address: Laurel Md
19. Jan. 22, 1945 (Date rec'd by registrar) Albert R. Sumwalt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 1945, at 3:00 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 1944, to Jan. 22, 1945
and that I last saw him alive on Jan. 22, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8-1-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 1-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

00323

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore ~~City~~ Co.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 917 St. Charles Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Verna Magdaline Collins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Charles Collins
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) ~~Deceased~~ Nov. 28, 1905

8. AGE:

Years	Months	Days	If less than one day
39	1	10	____ hrs. ____ min.

9. Birthplace Hagerstown, Maryland- Washington county
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Lewis Willman
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden name Clara May Carbaugh
15. Birthplace Hagerstown, Maryland

16. Informant Miss Belva Willman
Mrs. Pauline Elliott, sisters
Address 917 St. Charles Street
Baltimore, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-12-45 (month) (day) (year)

Cemetery or crematory United Brethern

Location Thurmount Maryland

18. Funeral director Harry H. Witzke

Address 4101 Edmondson Ave.

19. 1/11 19 45 A. W. Hedrick Asst. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1945 at 7:40a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 16 1944 to Jan 8 1945 and that I last saw h-ess alive on Jan. 7 1945

Immediate cause of death	DURATION
Empyema (left side)	unk
Due to Perforated Lung abscess	unk
Due to	
Due to	
Other conditions Chronic Interstitial Nephritis	6 yrs.
Toxic Psychosis (endogenous)	2 mos.

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Edward J. Kernan M. D. or other

Address Sykesville, Md Date signed 1-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-A)

00324

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Florville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Florville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Sykesville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mattie L. Colson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Oliver Colson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 26, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	7	..... hrs. ..... min.

9. Birthplace: Carroll Co. Md

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Joseph F. Fisher

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Ida J. Evans

15. Birthplace: Maryland

16. Informant: Mrs. Bessie M. Hunger Sad

Address: R.D. Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-6-45 (month) (day) (year)

Cemetery or crematory: Morgan Chapel

Location: Day, Carroll Co. Md.

18. Funeral director: C. M. Warfield

Address: Winfield, Md.

19. Jan 5 1945 (Date rec'd by registrar) C. Harry Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 3, 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 1944, to Jan. 3 1945

and that I last saw h.er alive on Jan. 3 1945

Immediate cause of death	DURATION
Chr. Valv. Heart Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Md Date signed: 1/4/45

Evidence for change of year of birth [illegible]

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILM No. G 94 MAY 14 1945

937

00325

1. PLACE OF DEATH

County Carroll Registration Dist. No. 50

Village or City New Windsor No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Louis P. (Zepp) Cook If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Cook Widowed

6. DATE OF BIRTH (month, day, and year) August 9 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	5	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Carroll Co. Md. (State or country)

FATHER

13. NAME Georg W. Zepp

14. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

MOTHER

15. MAIDEN NAME Josephine Barnes

16. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

17. INFORMANT Mrs. Charles Bankard (Address) New Windsor Md.

18. BURIAL, CREMATION, OR REMOVAL Presbyterian cemetery Place New Windsor, Md. Date Jan. 12, 1945

19. UNDERTAKER C. Bankard & Son (Address) Westminster, Md.

20. FILED Jan 12, 1945 Erwin E. Benedict Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 12 (Month) (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from 1942 to January 12 1945; that I last saw h alive on January 12 1945; daath is said to have occurred on tha date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerotic C-V disease	4

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) James J. Moore M. D.

(Address) Westminster Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

00326

Reg. Dist. No. 75

1. PLACE OF DEATH:
County Carroll
City or town Alesia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Alesia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George E Ehrhart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Lizzie A Ehrhart
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Sept 23 - 1875

8. AGE:

Years	Months	Days	If less than one day
69	3	11	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Samuel Ehrhart
13. Birthplace: Md

MOTHER
14. Maiden name: Gertrude Waldman
15. Birthplace: Md

16. Informant: Elmer Ehrhart
Address: Alesia Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7/45 (month) (day) (year)
Cemetery or crematory: Hilltop
Location: York Co - Pa.

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Jan. 6 (Date rec'd by registrar) 1945 Mrs. W. P. S. Benner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1945, to January 4 1945
and that I last saw him alive on January 4 1945

Immediate cause of death	DURATION
Hypertensive Cardio - Renal	?
Due to Vascular Disease	
Due to Chr. Interstitial Nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Jacob E. Buck M.D. M. D. or other
Address: Hampstead Md Date signed: 1/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (P3)

CERTIFICATE OF DEATH

00327

Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Isabella Fisher

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	widow

6.(b) Name of husband or wife: Milton Fisher

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 17, 1861

8. AGE: Years: 83 | Months: 1 | Days: 26 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Edward Strevig

13. Birthplace: Md

MOTHER 14. Maiden name: Susan Copenhaver

15. Birthplace: Md

16. Informant: Edward Strevig
Address: Westminster R.F.D.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Jan 15, 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Valley

Location: Pleasant Valley

18. Funeral director: C. E. Fuss & Son

Address: Taneytown, Md.

19. Jan 14 45 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12th 1945, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 th 1945, to Jan 12 th 1945 and that I last saw h.. alive on Jan 12 th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Benner MD
M. D. or other
Address: Taneytown Md Date signed: 1/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

00328

CERTIFICATE OF DEATH

Reg. Diat. No. 72

1. PLACE OF DEATH:
County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Taneytown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah R. Fringer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Calvin T. Fringer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18, 1865

8. AGE:	Years	Months	Days	If less than one day
	79	7	11	....hrs. ....min.

9. Birthplace Carroll County, Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name David Panebaker
13. Birthplace Maryland

MOTHER
14. Maiden name Hannah L. Bigler
15. Birthplace Maryland

18. Informant Dr. C. M. Benner
Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-1-45 (month) (day) (year)
Cemetery or crematory Reformed Cemetery
Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son
Address Taneytown, Md.

19. Jan 31 1945 Ethel M. Mehring Registrar
(Date rec'd by registrar) Local

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25th 1945, to Jan 29th 1945
and that I last saw her alive on Jan 29th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D.
M. D. or other
Address Taneytown Md Date signed 1-30-45

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00329

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months, 23 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 209 N. Gilmore St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ALBERT GLADDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Ella Gladden
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 22, 1910

8. AGE: Years	Months	Days	If less than one day
34	2	19	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Alfred Gladden
13. Birthplace: Maryland
MOTHER 14. Maiden name: Victoria Brooks
15. Birthplace: Virginia
16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1945 (month) (day) (year)
Cemetery or crematory: Int. Arbutus Cem
Location: Landsdown.
18. Funeral director: Katie Williams.
Address: 322 N. Schroeder St.
19. Jan. 10, 1945 (Date rec'd by registrar) Albert L. Swandner Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1945, at 10:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1944, to Jan. 10, 1945 and that I last saw him alive on January 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 12 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00330

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Woodbine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Samuel S. Gosnell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife: Gladys E. Gosnell
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Jan. 25, 1868

8. AGE:

Years	Months	Days	If less than one day
76	11	20	..... hrs. ..... min.

8. Birthplace: Frederick Co. Maryland.
(Town, county, and state)
10. Usual occupation: Electrician (Retired)
11. Industry or business

FATHER
12. Name: Francis W. Gosnell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Lugenbeal
15. Birthplace: Maryland

18. Informant: Mrs. Gladys E. Gosnell
Address: Woodbine, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 1-17-45 (month) (day) (year)
Cemetery ~~or crematory~~: Maryan Chapel
Location: Day. Carroll Co. Md.

18. Funeral director: C. M. Walls
Address: Winfield Md

19. Jan 17 1945 (Date rec'd by registrar) J. William Glenn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 15, 1945 at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 to Jan 14 1945
and that I last saw h... alive on Jan 13 1945

Immediate cause of death	DURATION
Carcinoma of Prostate	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. H. Barnes M.D. M. D., or other
Address: Sykesville Date signed: 1/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

00331

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 90 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Fannie Haines

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

B.(b) Name of husband or wife: Nathan Haines
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 9, 1853

8. AGE: Years: 91 | Months: 2 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Abram Stultz
13. Birthplace: md

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: LeRoy Haines
Address: Uniontown, Md

17. Burial, cremation, or removal. Which: Burial
Date thereof: Jan 20, 1945 (month) (day) (year)
Cemetery or crematory: Ch of God
Location: Uniontown Md

18. Funeral director: C.O. Duttera Son
Address: Taneytown, Md.

19. Jan 19 1945 (Date rec'd by registrar)
Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18, 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to Jan 18, 1945
and that I last saw h.er alive on Jan 18, 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J H Legg M. D. or other
Address: Union Mills Date signed 1-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00332

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 30 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 520 W. Preston Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: DOROTHY ELIZABETH HENSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Norman Henson
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): August 28, 1919

8. AGE: Years	Months	Days	If less than one day
25	4	16	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Daniel Johnson
13. Birthplace: Unknown

MOTHER — 14. Maiden name: Lela Williams
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem
Location: Balto Md

18. Funeral director: G. H. Dodrer
Address: 1918 Eutaw Place Balto Md

19. Jan. 13, 1945 (Date rec'd by registrar) Albert R. Swankburn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1945 at 2:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14, 1944, to Jan. 13, 1945 and that I last saw her alive on January 13, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Oct. 1943
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

00333

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 29 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Milton George Hiss (George Wilton Hiss)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Effie Walter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9, 1887

8. AGE: Years	Months	Days	If less than one day
57	7	20	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Railroad

FATHER
12. Name: Frank Hiss
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nannie Hopkins
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-1-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem.
Location: Frederick Rd.
18. Funeral director: James L. McCauley
Address: 130 E. Fort Ave.

19. 1/31/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 19 45 at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 19 44 to Jan. 29 19 45 and that I last saw him alive on January 28 19 45

Immediate cause of death	DURATION
Cerebral hemorrhage	36 hrs.
Due to: Arteriosclerosis, prior to	1936
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

00334

CERTIFICATE OF DEATH

Reg. Dist. No. 71

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Westminster (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Finksburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ella Missouri Hively

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband ~~or wife~~: John C. Hively
6.(c) If alive, give age: ....years
7. Birth date of deceased (mo., day, yr.): March 3-1867
8. AGE: Years: 77 Months: 10 Days: 12 If less than one day: ....hrs. ....min.
9. Birthplace: Carroll County Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business
FATHER 12. Name: Andrew Myers
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mandella Myers
MOTHER 15. Birthplace: Maryland
16. Informant: Mrs. C. O. Garner
Address: Westminster Md. R.D. 7
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 18-1945 (month) (day) (year)
Cemetery ~~or crematory~~: Meadow Branch Cem.
Location: Finksburg Road
18. Funeral director: H. H. Harbaugh & Sons
Address: Union Bridge & New Windsor Md.
19. January 17 1945 (Date rec'd by registrar) Margaret P. England Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 15 1945, at 7:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14- 1945 to Jan 15 1945
and that I last saw h.. alive on Jan 14- 1945

Immediate cause of death	DURATION
Myocarditis (chr)	
Hypertension (chr)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Wm. C. Jennette M.D.
M. D. or other
Address: Westminster Md. Date signed 1-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

00335

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 15 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 2 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Theodore Hoffacker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Eliza Warner
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18, 1859

8. AGE: Years	Months	Days	If less than one day
85	9	23	....hrs. ....min.

9. Birthplace: nr. Alesia, Carroll Co., Md.
(Town, county, and state)
10. Usual occupation: farming
11. Industry or business: agriculture

FATHER
12. Name: Jacob Hoffacker
13. Birthplace: Carroll County, Maryland

MOTHER
14. Maiden name: Susanna Markey
15. Birthplace: Baltimore County, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 1945 (month) (day) (year)
Cemetery or crematory: Manchester Cemetery
Location: Manchester, Md.
18. Funeral director: Jacob Weiskotten & Sons
Address: Manchester, Md.
19. Feb. 3 1945 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1945 at 5:35 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1945 to Jan. 31 1945 and that I last saw him alive on January 31 1945

Immediate cause of death	DURATION
Senility	1 year
Due to:	
Due to:	
Other conditions: Senile psychosis, simple deterioration	1 year

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00336

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 16 days

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1211 Spring Street
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: FAYETTE HOOD

3.(b) Social Security Number: 220-09-4188

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

B.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 26, 1903

8. AGE: Years	Months	Days	If less than one day
41	11	18	hrs. min.

9. Birthplace: Lancaster, South Carolina
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Hood

13. Birthplace: Unknown

MOTHER — 14. Maiden name: ? Nelson

15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/15/45 (month) (day) (year)

Cemetery or crematory: Mt Calvary

Location:

18. Funeral director: Fremont A. Hensley

Address: 578 W. Baltimore St.

19. Jan. 13, 1945 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1945, at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1944 to Jan. 13, 1945 and that I last saw him alive on Jan. 13, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 1-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00337

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs 3 mo 10 d 2

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 15 yrs 3 mo 10 d 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Cypress

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maud V. Hoover

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 9 1876

8. AGE: Years 68 | Months 4 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington County Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William H. Hoover

13. Birthplace Washington County Md

MOTHER 14. Maiden name Helen Bigham

15. Birthplace Washington County Md

16. Informant Hospital Records

Address Sykesville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director P. R. Coffman

Address Hagerstown, Md.

19. Jan 16 1945 (Date rec'd by registrar) C. Harry Eberly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16, 1945 at 4.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 21, 1929 to Jan. 16 1945 and that I last saw h.. alive on January 16 1945

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	10 yrs
Due to	
Due to	
Other conditions Lobar pneumonia Puerperal type (Include pregnancy within 3 months of death)	48 hrs

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M. Rea M.D. M. D. or other

Address Sykesville Md Date signed 1-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

00338

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Franklin Houck

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 17, 1860

8. AGE: Years: 84 | Months: 5 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: William Houck
13. Birthplace: Md

MOTHER
14. Maiden name: Ellen Burlinger
15. Birthplace: Md

16. Informant: William M. Houck
Address: Taneytown R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20, 1945 (month) (day) (year)
Cemetery or crematory: St. Jacob's
Location: Taneytown, Md

18. Funeral director: Jos. Sauerhammer
Address: Taneytown, Md

19. Jan 18 1945 (Date rec'd by registrar) Ethele M Mehring Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1944, to Jan 13 1945
and that I last saw him alive on 1-13- 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. S. Rigg, M. D. or other
Address: [illegible] Date signed 1-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

00339

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above piece of death? 18 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: St. Paul & 31st. Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ZEB HOWELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec., 25, 1889

8. AGE: Years	Months	Days	If less than one day
55	0	9	hrs. min.

9. Birthplace: Monroe, N. C.
(Town, county, and state)
10. Usual occupation: Fireman
11. Industry or business:

FATHER
12. Name: Charles Howell
13. Birthplace: Greenville, N. C.

MOTHER
14. Maiden name: Adeline Morrow
15. Birthplace: Greenville, N. C.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7 1945 (month) (day) (year)
Cemetery or crematory Mt. Calvary
Location Catonsville Md.
18. Funeral director A. Hahle & Bro.
Address 918 Druid Hill Ave.

19. 1/3 (Date rec'd by registrar) 1945 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3, 1945, at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec., 16, 1945, to Jan., 3, 1945 and that I last saw him alive on January 3, 1945

Immediate cause of death	DURATION
Lobar Pneumonia	11-15-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 1/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 003407 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all Car life

Hospital, Institution, or street address where death occurred:

Charles St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Charles St. Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war X

3.(a) FULL NAME Mary Ellen Hughes

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	Col.	widowed

6.(b) Name of husband or wife Elmer Cross

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 1869

8. AGE:

Years	Months	Days	If less than one day
75	7	?	..... hrs. ..... min.

9. Birthplace Westminster Carroll Md.

(Town, county, and state)

10. Usual occupation House work (servant)

11. Industry or business

FATHER

12. Name Robert Hughes

13. Birthplace Carroll Co. Md.

MOTHER

14. Maiden name Jane Pye

15. Birthplace Carroll Co. Md.

16. Informant Miss Peggie Hughes

Address Charles St. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 4 45 (month) (day) (year)

Cemetery or crematory Western Chapel Cem.

Location Rural nr. Westminster Md.

18. Funeral director J. E. Myers, Jr.

Address Westminster Md.

19. 1/2 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 - 45 19 11 at 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 ..... to 1 - 1 - 19 45

and that I last saw h... alive on 12 - 31 - 44 19 .....

Immediate cause of death	DURATION
Myocarditis (chr)	years
Hypertns (chr)	years
Due to	
Due to	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. C. Jennette M.D.

M. D. or other

Address Westminster Md. Date signed 1 - 3 - 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00341

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 DAYS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County:

City or town: BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3213 VIRGINIA AVENUE

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ELIZABETH S. JARMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: GEORGE JARMAN

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): MARCH 27, 1885

8. AGE:

Years	Months	Days	If less than one day
59	9	8	hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business:

FATHER

12. Name: GEORGE SHAW

13. Birthplace: ENGLAND

MOTHER

14. Maiden name: MYRA FOREST

15. Birthplace: ENGLAND

16. Informant: MRS C.H. KABLE

Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/45 (month) (day) (year)

Cemetery or crematory: LOUDON PARK CEMETERY

Location: BALTIMORE, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER MD.

19. 1/5 19 45 (Date rec'd by registrar) L.C. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 4 19 45, at 11:50 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 2 19 45, to Jan 4 19 45

and that I last saw h[er] alive on Jan 4 19 45

	DURATION
Immediate cause of death: Coronary occlusion	2 hrs.
Due to: myocardial degeneration & arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other

Address: Westminster Date signed: Jan 4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00342

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs 4 mos
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 15 yrs 4 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Ft Roots
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Fildon Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years	Months	Days	If less than one day
50	4		hrs. min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: not any
11. Industry or business:
FATHER 12. Name: Andrew Jones
13. Birthplace: South Carolina
MOTHER 14. Maiden name: Susan Powers
15. Birthplace: North Carolina
16. Informant: Andrew Jones
Address: Ft Roots Md
17. Burial: (Burial, cremation, or removal. Which?) Date thereof: Jan 30-45 (month) (day) (year)
Cemetery or crematory: Centre
Location: Forest Hill - Harford Co
18. Funeral director: Masters & Hunt
Address: Jarrettsville Md
19. Jan 28 1945 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945, at 6 P M
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Oct 26 1928, to Jan 27 1945
and that I last saw alive on Jan 27 1945

	DURATION
Immediate cause of death: Broncho Pneumonia	3 da
Due to: Chronic Myocarditis	?
Due to: Epilepsy	49 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. H. Hasty M. D. (M. D. or other)
Address: Sykesville Md Date signed: 1/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00343 81

Reg. Dist. No.

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Henry Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Bessie L. Jones
~~1880 - 5 - 11~~ 6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): 1880 - 5 - 11

8. AGE: Years	Months	Days	If less than one day
64	8	13	hrs. min.

9. Birthplace: Carroll Co
(Town, county, and state)
10. Usual occupation: Labor
11. Industry or business

FATHER
12. Name: Adam Jones
13. Birthplace: Carroll Co

MOTHER
14. Maiden name: Anna Stonesifer
15. Birthplace: Carroll Co

16. Informant: Mrs. Bessie Jones
Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-45 (month) (day) (year)
Cemetery or crematory: Lutheran Cemetery
Location: Uniontown Md

18. Funeral director: Raymond K. Wright
Address: Union Bridge Md

19. Jan 19 45 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1945, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James T. Mount, Deputy Medical Examiner
M. D. or other
Address: Hereford Md Date signed: 1/18/45

(M)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Midland Cy
Registrar
Margaret P. Englar

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

00344

Reg. Dist. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosada Kayler

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife Howard Kayler
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 22, 1921

8. AGE: Years	Months	Days	If less than one day
24	0	14	hrs. min.

9. Birthplace Uniontown, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name James Elias Wilson
13. Birthplace Uniontown, Md.
MOTHER 14. Maiden name Annie Spurrier
15. Birthplace Uniontown Md.
16. Informant Mrs Paul Will
Address Uniontown, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan-8-1945 (month) (day) (year)
Cemetery or crematory Methodist cem.
Location Uniontown, Md.
18. Funeral director H Bankard Sons
Address Westminster, Md.
19. Jan 8 1945 (Date rec'd by registrar) Margaret P. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 2 1944, to Jan 6 1945
and that I last saw h.er alive on Jan 6 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. S. Legg M. D. or other
Address Union Bridge Date signed 1-6-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

00345 76

Reg. Dist. No. (74)

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Fringelburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Carroll

City or town Fringelburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Louise Kline

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1884

8. AGE: Years 60 | Months 8 | Days 6 | If less than one day hrs. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Louis P. Kline

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden name Philippine Dawy

MOTHER 15. Birthplace Balto. Md.

16. Informant Jacob Kline

Address 1431 N. Milton Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1945 (month) (day) (year)

Cemetery or crematory Trinity Cemetery

Location O'Donnell St. Balto. Md.

18. Funeral director John C. Miller Son

Address Balto., Md.

19. Jan. 30 1945 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1945 at 10:35 P.M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Jan 29- 1945 to Jan 29- 1945 and that I last saw h.. alive on Jan 29- 1945

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Due to	
Other conditions Senile Debility (Chronic)	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jennette M.D.

Address Westminster Md. M. D. or other

Date signed 1-30-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

00346

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 YRS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 32 W. GEORGE ST.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: ANNIE BETTIE KNADLER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: SAMUEL J. KNADLER

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): DECEMBER 26, 185[illegible]

8. AGE:

Years	Months	Days	If less than one day
9[illegible]	0	18	..... hrs. ..... min.

9. Birthplace: CARROLL CO. MD.
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: JOHN H. SHEWBRIDGE
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: BARBARA WHITTINGTON
15. Birthplace: VIRGINIA

16. Informant: JESSIE KNADLER
Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1/16/45 (month) (day) (year)

Cemetery or crematory: WESTMINSTER

Location: WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 1/15/45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 13 19 45, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 19 45, to January 13 19 45 and that I last saw h[illegible] alive on January 13 19 45

Immediate cause of death	DURATION
Lobar Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Westminster Maryland Date signed: 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

00347

CERTIFICATE OF DEATH

Reg. Diat. No. 94

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 3 mos 29 da

Hospital, institution, or street address, where death occurred: Springfield State Hospital

How long in hospital or institution? 3 yrs 3 mos 28 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: Unk (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Beulah Hamilton Dwight

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 50 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation:

11. Industry or business: dependent

FATHER 12. Name:

FATHER 13. Birthplace: Unknown -

MOTHER 14. Maiden name: Mollie Berg

MOTHER 15. Birthplace: Maryland.

16. Informant: Robert Dwight

Address: 820 W Pratt St. Balto

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 31, 1945 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Jan 31 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1945 at 11-45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1941 to Jan 28 1945 and that I last saw h[illegible] alive on Jan 28 1945

Immediate cause of death	DURATION
Stenosis of Left	
Due to: pulmonary Vein	1 day
Due to: Organic Brain	abt life
Other conditions: Disease	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Gantz M.D. M. D. or other

Address: Sykesville Date signed 1-28-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00348

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yr., 8 mo., 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 yr., 8 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1518 N. Collington Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louis John Loritz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Estella Oswinkle
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 15, 1883

8. AGE: Years	Months	Days	If less than one day
61	4	28	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Millwright
11. Industry or business: Bethlehem Steel Company

FATHER
12. Name: Henry Loritz
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Katherine Eckles
15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 16, 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn Cemetery
Location: Balto. Md.
18. Funeral director: H. Sanders & Son
Address: North ave & Broadway

19. Jan. 14 1945 (Date rec'd by registrar) C. Harry Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 19 45 at 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to January 13 19 45 and that I last saw him alive on January 13 19 45

Immediate cause of death	DURATION
Aortic aneurysm, prior to	11-28-44
Due to Syphilis (general paresis) prior to	1930
Due to Diabetes mellitus, prior to	1941
Other conditions Psychoneurosis, reactive depression	9 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May M.D.
M. D. or other
Springfield State Hospital
Address: Sykesville, Maryland
Date signed: 1-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00349

Reg. Diat. No. 71

1. PLACE OF DEATH:

County: Carroll

City or town: Frizellburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Lloyd W. Mason

3. (b) Social Security Number 213-18-1709

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife: Mary A. Mason

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 21, 1864

8. AGE: Years	Months	Days	If less than one day
80	4	18	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Stationary Fireman

11. Industry or business:

FATHER 12. Name: John Mason

13. Birthplace: Md

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: J. A. Mason

Address: R. Westminster #7

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 10, 1945 (month) (day) (year)

Cemetery or crematory: Meadow Branch

Location: Nr. Westminster

18. Funeral director: C. Pinsost Son

Address: Taneytown, Md

19. Jan 9 (Date rec'd by registrar) 19 45 Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8 19 45, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 44, to Jan 19 45

and that I last saw him alive on Jan 6 19 45

Immediate cause of death	DURATION
Arteriosclerotic heart disease & hypertension	1 yr.
Due to: Cerebral softening	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Milton A. Katz M.D. (M. D. or other)

Address: Westminster Date signed: 1/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00350

(107)

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 1 mo

Hospital, institution, or street address where death occurred: Spring field State Hosp.

How long in hospital or institution? 1 yr 11 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Washington

City or town: Hagerstown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna R McCardell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Unknown

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 25 - 1861

8. AGE: Years: 83 | Months: 3 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Timothy Ryan

13. Birthplace: Ireland

MOTHER 14. Maiden name: Ann M Guerney

15. Birthplace: Ireland

16. Informant: Mrs Alice Lynch 1163 Hamilton Blv. Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md.

19. Jan 28 1945 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 27 1945 at 12-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1943 to Jan 27 1945

and that I last saw h.. alive on Jan 27 1945

Immediate cause of death	DURATION
Bronchopneumonia	5 da
Due to:	
Due to: Gangrene of Foot	2 mo
Other conditions: Arteriosclerosis	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W G Wastan M.D. M. D. or other

Address: Sykesville Md Date signed 1/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (842)

CERTIFICATE OF DEATH

00351 P

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yr., 8 mo., 21 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 26 yr., 8 mo., 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John McDonald

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 8, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	13	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Lawrence McDonald
13. Birthplace: Baltimore City, Maryland

MOTHER
14. Maiden name: Mary O'Brien
15. Birthplace: Baltimore City, Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 24 1945 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Baltimore City
19. Funeral director: John M. Welbes
Address: 404 S. Chester Street

19. 1/23 19 45 (Date rec'd by registrar) A. W. Hedrick per S.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 19 45 at 3:25a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43 to Jan. 21 19 45 and that I last saw him alive on January 20 19 45

Immediate cause of death	DURATION
Senility	6 years
Due to:	
Due to:	
Other conditions: Alcoholic hallucinosis	28 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00352

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 10 mos., 29 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium (Colored Branch), Henryton, Md.
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 703 Druid Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: SAM McELVEN

3.(b) Social Security Number: 213-09-0720

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1903

8. AGE: Years	Months	Days	If less than one day
41	1	0	hrs. min.

9. Birthplace: Williamsburg, S.C.
(Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: --

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden name: unknown
15. Birthplace: "

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Md.

17. Removal (Burial, cremation, or removal, which?) Date thereof: Jan. 9, 1945 (month) (day) (year)
Cemetery or crematory: Fraternal Cemetery
Location: Balto. Md.
18. Funeral director: F. H. Zepp
Address: 578 W. Biddle St.

19. Jan. 7 1945 (Date rec'd by registrar) Albert R. Scrambler deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1945 at 12:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1940 to January 7 1945 and that I last saw him alive on January 7 1945

	DURATION
Immediate cause of death: Pulmonary tuberculosis	Oct. 1939
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 1-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

00353

CERTIFICATE OF DEATH

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? Seven days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Pikesville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas Minor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Holbeard Minor

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Mar 21 1885

8. AGE: Years	Months	Days	If less than one day
~~55~~ 59	10	20	____ hrs. ____ min.

9. Birthplace: York (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: John Minor

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Virginia

16. Informant: Gladys Kearns

Address: Reisterstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 45 (month) (day) (year)

Cemetery or crematory: Reisterstown Methodist

Location: Reisterstown

18. Funeral director: J. F. Cline & Sons

Address: Reisterstown Md.

19. Jan 11 1945 (Date rec'd by registrar) C. Harry Ward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1945 at 7:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4 1945 to Jan 10 1945 and that I last saw h... alive on Jan 10 1945

Immediate cause of death	DURATION
Lobar Pneumonia (Bilateral) Terminal	2 days.
Due to: Chronic Myocarditis	unk.
Due to: Generalized Arteriosclerosis.	unk.
Other conditions: Syphilis.	unk.
Psychosis & cerebral arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. or other

Address: Sykesville, Md Date signed 1-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

00354

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No. 230 E MAIN ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: CATHERINE H. MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: GEORGE H. MITCHELL

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ABOUT 1865

8. AGE: Years	Months	Days	If less than one day
ABOUT 80			..... hrs. ..... min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: NOT KNOWN
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: GEORGE R. MITCHELL
Address: WESTMINSTER, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/24/45 (mooth) (day) (year)

Cemetery or crematory: LOUDON PARK CEMETERY

Location: BALTIMORE MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD

19. 1/23/45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 22 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1941, to Jan 22 1945

and that I last saw h[illegible] alive on Jan 22 1945

	DURATION
Immediate cause of death: Myocardial degeneration	3 yrs
Due to: arteriosclerosis	indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Reese Wolbens M.D. or other M.D.

Address: Westminster Date signed 1/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-1)

00355

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 5 mos 15 da

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 17 yr. 8 mos 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Estella Hoate

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1866

8. AGE: Years: 78 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Simon Coffman

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary Boyd

MOTHER — 15. Birthplace: Maryland

16. Informant: Carl C. Coffman

Address: 27 Glenside Ave Hagerstown

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/45 (month) (day) (year)

Cemetery or crematory: Manor Cemetery

Location: Near Hagerstown Md

18. Funeral director: A K Coffman

Address: Hagerstown Md

19. Jan 4 1945 (Date rec'd by registrar) C. Henry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1st 1945 at 9-45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1943, to Jan 1st 1945

and that I last saw h alive on Jan 1st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	10 da
Due to:	
Due to Arteriosclerosis	
Hypertension	10 yrs
Other conditions	

(Include pregnancy withio 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. J. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed 1/1/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-a

00356

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County CARROLL

City or town NEAR WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLL

City or town NEAR WESTMINSTER

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME VIENA O. MYERS

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife FRANKLIN H. MYERS

8.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1859

8. AGE: Years	Months	Days	If less than one day
85	8	24	...hrs. ...min.

9. Birthplace CARROLL COUNTY, MD. (Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER 12. Name CYRUS SCHWEIGART

13. Birthplace MD.

MOTHER 14. Maiden name NOT KNOWN

15. Birthplace " "

16. Informant MRS. H. G. SHAFFER

Address WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1/8/45 (month) (day) (year)

Cemetery or crematory KRIDERS CEMETERY

Location WESTMINSTER, MD.

18. Funeral director J. FRANCIS REESE

Address WESTMINSTER, MD.

19. 1/6 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 4 19 45 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 1944, to Jan 1st 19 45 and that I last saw h.e.r. alive on Jan 4th 19 45

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address 1 W. Main St Westminster Date signed Jan 4 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00357

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 12 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Oppel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Edna
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 13, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	15	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Box factories

FATHER
12. Name: John Oppel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Rep
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 31, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.
18. Funeral director: John F. Denny Inc.
Address: Light & Montgomery Sts.
19. Jan 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1945 at 7:20a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 5 1944 to Jan. 28 1945 and that I last saw him alive on January 27 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	4½ hrs.
Due to: Arteriosclerosis, prior to	1940
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis, prior to	6-16-44

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.
23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 1-28-45

Evidence for addition of age of deceased is shown on FILM No. G 92 MAR 10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

00358

Reg. Diat. No. .....

1. PLACE OF DEATH:

County ... Carroll

City or town ... Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ... 6 yrs 3 mo 6 da

Hospital, Institution, or street address where death occurred: ... Springfield State Hospital

How long in hospital or institution? ... 6 yrs 3 mo 6 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ... Md County .....

City or town ... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME John Patterson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife ... unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ... Dec 17 1861

8. AGE: Years: 83 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace ... Scotland (Town, county, and state)

10. Usual occupation ... construction Worker

11. Industry or business .....

FATHER — 12. Name ... John Patterson

13. Birthplace ... Scotland

MOTHER — 14. Maiden name ... unknown

15. Birthplace ... Scotland

16. Informant ... Mrs Bessie Sheets

Address ... 921 E Oliver St. Balto

17. ... Burial ... Date thereof 1-5-45 (mo.) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory ... Baltimore Cemetery

Location ... E. North Ave

18. Funeral director ... Wendell & Humphreys

Address ... 521 N. Broadway

19. ... 1/4 45 ... Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ... Jan 3 d 19 45 at 6-45 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 26 19 28, to Jan 3 19 45

and that I last saw h in alive on Jan 3 d 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	4 hrs
Due to Chronic Myocarditis	15 yrs
Due to Arteriosclerosis	12 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results Coronary Thrombosis, Chronic Myocarditis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE ... W. F. Martin M.D.

M. D. or other

Address ... Sykesville Date signed 1/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

00359

CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy. Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy. Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Corwin C. Penn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mertie L. Penn.
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1873

8. AGE:

Years	Months	Days	If less than one day
71	3	28	hrs. min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)
10. Usual occupation: Farmer (Retired)
11. Industry or business

FATHER
12. Name: Milton H. Penn
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Mary K. Grimes
15. Birthplace: Maryland.

19. Informant: Mr. Ferris Penn.
Address: Mt. Airy. Md.

17. Burial (Burial, ~~cremation, or removal~~, Which?) Date thereof: 1-30-45 (month) (day) (year)
Cemetery or ~~crematory~~: Bethel Church of God
Location: Near Winfield, Carroll Co. Md.
19. Funeral director: C. M. Walz
Address: Winfield Md.

19. Jan. 29 1945 (Date rec'd by registrar) Thos. D. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28, 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1943, to Jan 28 1945 and that I last saw h... alive on Jan 28 1945

Immediate cause of death: Carcinoma of Stomach with General Metastasis — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. M. Walz M. D. or other
Address: Mt Airy Md Date signed: 1-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00360

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Rural

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur Ambrose Perry

3.(b) Social Security Number: 705-10-6022

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife: Gene L Perry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 3-1876

8. AGE: Years	Months	Days	If less than one day
68	11	14	..... hrs. ..... min.

9. Birthplace: Frederick County, Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: W.M. R.R. Shops

FATHER — 12. Name: Melvin J Perry

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Jennie Dyer

MOTHER — 15. Birthplace: Maryland

18. Informant: Romeo P. Perry

Address: New Windsor Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20-1945 (month) (day) (year)

Cemetery or crematory: Pipe Creek Cemetery

Location: Uniontown Road

18. Funeral director: H. D. Harbaugh & Sons

Address: Union Bridge & New Windsor Md

19. January 19 1945 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17 1945, at 6.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 17 1945

and that I last saw him alive on Jan 17 1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Legg M.D. or other

Address: Union Bridge Date signed 1-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

00361

CERTIFICATE OF DEATH

Reg. Diat. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Rural - Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taylorsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. Mt. Airy.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Verdie V. Pickett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Gene Pickett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1870

8. AGE:

Years	Months	Days	If less than one day
74	1	8	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: George W. Harn

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Catherine P.

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. William Hooper

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal~~. Which?) Date thereof 1-22-45 (month) (day) (year)

Cemetery or ~~crematory~~: Taylorsville

Location: Taylorsville, Carroll Co. Md

18. Funeral director: C. M. Walter

Address: Winfield, Md.

19. Jan. 21 1945 E. M. Fenn Local Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1945 at 3:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 1943 to Jan 19 1945

and that I last saw her alive on January 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs.
Due to: Hypertension Arteriosclerosis C-V disease	Years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE: James T. Harn M. D. or other

Address: New Windsor Md Date signed 1/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 00362

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County Carroll
City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs 5 mos 17 days
Hospital, Institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 27 yrs. 5 mos. 17 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 2915 Frankstown Rd (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Carrie Reith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1893

8. AGE: Years	Months	Days	If less than one day
51	10	2	hrs. min.

9. Birthplace Baltimore (Town, county, and state) Maryland

10. Usual occupation none

11. Industry or business

FATHER
12. Name Theska Reith
13. Birthplace Germany

MOTHER
14. Maiden name Susan Bennick
15. Birthplace Maryland

16. Informant Hospital Records
Address Sykesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/19/45 (month) (day) (year)
Cemetery or crematory Druid Ridge
Location Catonsville Md

18. Funeral director H. Trostel Sons
Address North & Eutaw

19. (Date rec'd by registrar) 1/17 1945 C. W. Leitch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 6 1945 to January 15 1945 and that I last saw h alive on January 15 1945

Immediate cause of death	DURATION
Lobar Pneumonia	9 days
Due to	
Due to	
Other conditions Generalized Cancer	27 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Maud M. Rees M D
M. D. or other
Address Sykesville Md Date signed 1-15-45

Rec'd. U. S.
1/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00363

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 629 East 28th. St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PATRICIA ALFREDA ROSS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1920

8. AGE: Years	Months	Days	If less than one day
24	2	28	hrs. min.

9. Birthplace: Dinwiddie, Virginia (Town, county, and state)
10. Usual occupation: Waitress
11. Industry or business:

FATHER
12. Name: Waverly Ross
13. Birthplace: Dinwiddie, Virginia

MOTHER
14. Maiden name: Clara Hardy
15. Birthplace: Dinwiddie, Va.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/31/45 (month) (day) (year)
Cemetery or crematory: Fellowship Cemetery
Location: Fellowship Church, Virginia

18. Funeral director: Mrs Ida Bailey
Address: 1421 Jefferson St

19. Jan. 30, 1945 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9, 1944 to Jan. 30, 1945 and that I last saw her alive on Jan. 30, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Nov. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00364

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 Hersh Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Peter Milton Rathrauff

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Fannie Blair

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26 1867

8. AGE: Years	Months	Days	If less than one day
77	5	6	..... hrs. ..... min.

9. Birthplace Williamsport, Md.

(Town, county, and state)

10. Usual occupation Carpenter: Supt.

11. Industry or business

FATHER 12. Name Peter South Rathrauff

13. Birthplace Md.

MOTHER 14. Maiden name Mary Ann Hauser

15. Birthplace Md.

16. Informant Mrs. John Everhart

Address 17 Hersh Ave, Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 4th 1943 (month) (day) (year)

Cemetery or crematory Rridge cemetery

Location Westminster, Md.

18. Funeral director Bankard & Son

Address Westminster Md.

19. 1/3 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 19 43 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1st 19 43, to Jan 2nd 19 43

and that I last saw him alive on Jan 2nd 19 43

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. Stewart Westmuller M. D. or other

Address June 3rd 1943 Date signed

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of cause of death is shown on FILM No. G 94 APR 7 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

00365

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Gamber Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Gamber Md
How long in hospital or Institution? 2 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Gamber Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary A. Savage

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Frank Savage
6.(c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) Dec 8 1900

8. AGE: Years 44 | Months 1 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace Carroll Co Maryland (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John J. Bahn
13. Birthplace Maryland
MOTHER 14. Maiden name Eliza E. Hanley.
15. Birthplace Maryland
16. Informant Mr. Frank Savage
Address Finksburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-45 (month) (day) (year)
Cemetery or crematory Providence
Location Gamber Carroll Co Md
18. Funeral director C. M. Walsh Inc
Address Westminster
19. 1-12 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1945, at 12 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1944, to January 11 1945 and that I last saw her alive on January 10 1945

	DURATION
Immediate cause of death Intestinal Obstruction	1 wk
Due to Generalized Carcinomatosis ?	
Probably primary carcinoma of the liver. C.W.B.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Generalized Carcinomatosis
Date of op. Nov 30, 44
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Jos E. Bush M.D. M. D. or other
Address Hampstead Md Date signed 1-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

CERTIFICATE OF DEATH

00366

Reg. Dist. No. 73

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Harney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma Jane Shildt

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: D. Theodore Shildt

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 6, 1868

8. AGE: Years	Months	Days	If less than one day
76	8	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: Tobias Stahl

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Susan Bowers

MOTHER 15. Birthplace: Penna.

16. Informant: Charles Shildt

Address: Taneytown, R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 9, 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Taneytown, Md.

18. Funeral director: C. O. Gusse Son

Address: Taneytown, Md.

19. Jan 8, 1945 (Date rec'd by registrar) Athele M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 1945, at 7:30 P. M. Prior to

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. T. Marsh Deputy Medical Examiner M. D. or other

Address: Taneytown, Md. Date signed Jan 5, 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99-d

00367

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. 6 Westminster
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary E. Shipley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

B.(b) Name of husband ~~or wife~~: F. Carroll Shipley.
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1868

8. AGE: Years	Months	Days	If less than one day
76	4	13	hrs. min.

9. Birthplace: Carroll Co. Maryland.
(Town, county, and state)
10. Usual occupation: Housework.
11. Industry or business:

FATHER
12. Name: Isaac Stimax
13. Birthplace: Germany

MOTHER
14. Maiden name: Emily ?
15. Birthplace: Germany.

16. Informant: Mrs. Della P. Eist.
Address: Sykesville. Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-21-45 (month) (day) (year)
Cemetery ~~or crematory~~: Bethesda
Location: Near Eist, Carroll Co. Md.

18. Funeral director: C. M. Walsh
Address: Winfield, Md

19. 1/20/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 18 19 45 at 10:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that ~~I~~ attended deceased from July 10 19 44, to Jan. 18 19 45
and that ~~I~~ last saw h~~im~~ alive on Jan. 18 19 45

Immediate cause of death	DURATION
Acute Coronary Thrombosis	2 hrs.
Due to: General Arteriosclerosis	5 yrs.
Due to: Hypertensive Vascular Disease	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Theodore Bond M.D.
M. D. or other
Address: Westminster Md. Date signed 1/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

00368

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-pd)

CERTIFICATE OF DEATH

Reg. Dist. No. 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Rural - Winfield
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural - Winfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary Jane Shipley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Hamlet Almer Shipley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 31, 1863

8. AGE: Years	Months	Days	If less than one day
81	4	21	..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: George H. Barnes
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ann Becraft
15. Birthplace: Maryland.

16. Informant: Miss Matilda Shipley
Address: Sykesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-24-45 (month) (day) (year)
Cemetery or ~~crematory~~: Ebenezer
Location: Winfield, Carroll Co. Md.
18. Funeral director: C. M. Watts
Address: Winfield, Md.

19. Jan 23 1945 (Date rec'd by registrar) Edna M. Hewitt Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1945 at 5 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to Jan 22 1945 and that I last saw h[er] alive on Jan 21 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardiovascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: Injured at work?

23. SIGNATURE: James T. Shank M. D. or other
Address: Westminster Md Date signed: 1/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00369

Reg. Dist. No. 82

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Ridgeville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Mt. Airy.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Gertrude Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ernest Smith
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1875

8. AGE:

Years	Months	Days	If less than one day
69	0	24	...hrs. ...min.

9. Birthplace: Howard Co. Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William W. Pickett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Bowman
15. Birthplace: Maryland

16. Informant: Mr. Ernest Smith
Address: Mt. Airy Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-6-45 (month) (day) (year)
Cemetery or crematory: Pine Grove
Location: Mt Airy, Carroll Co. Md.

18. Funeral director: C.M. Wantz
Address: Winfield Md

19. 1/5 (Date rec'd by registrar) 19 45 Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 1940 to December 3 1945 and that I last saw h[illegible] alive on ... 19...

Immediate cause of death	DURATION
(a) Cerebral Hemorrhages	5 hr 3 4 2 day
Due to (b) Arterio Sclerosis	5 yrs +
Due to (c) Hypertension	6 yr +
Other conditions Chr. Myocarditis	6 yr +

(Include pregnancy within 3 months of death)

Major findings of operation: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy, Md Date signed: 1/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00370

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 727 Sterling St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MILDRED ALVERA STEEPLE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Matthew Steeple
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): April 19, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: John Hamilton
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Lavania Dennis
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, Md.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: A. A. Co., Md.
18. Funeral director: Robert F. Stevens
Address: 1515 McElderry St

19. Jan. 4, 19 45 (Date rec'd by registrar) Albert R. Brandhorst Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4, 19 45 at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23, 19 44 to Jan. 4, 19 45 and that I last saw her alive on January 4, 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1944
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 1-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rec'd 1/9/45

Jan 7 D

STATE OF MARYLAND—CERTIFICATE OF DEATH

00371

(M)

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

1. PLACE OF DEATH

(61)

County Carroll — Registration Dist. No. 76

Village or City Westminster — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Jesse Lewis Stonus — If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Ann Rebecca Bush

6. DATE OF BIRTH (month, day, and year) March 23 - 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	9	16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer: Ret.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 1924

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

FATHER

13. NAME Ezra Stonus

14. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

MOTHER

15. MAIDEN NAME Clarissa Wampler

16. BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

17. INFORMANT Clayton Stonus
(Address) Garfieldsburg, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Sandymount Cem. Date Jan. 13, 1945

19. UNDERTAKER H Bankard & Son
(Address) Westminster Md.

20. FILED 1/11, 1945 — Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan. (Month) 10 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May, 1944, to Jan. 10, 1945

I last saw him alive on Jan. 10, 1945; death is said to have occurred on the date stated above, at 12:15 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Congestive Heart Failure	
Arteriosclerotic heart disease	
Other Contributory Causes of Importance: Diabetes mellitus	

Name of operation — Date of

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Milton A. Katz M. D.

(Address) Westminster, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (156-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 00372 76

1. PLACE OF DEATH:

County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs 7 21

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No. 15 Milton Ave. Extended
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Milton Augustus Sullivan

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Emma M. Little

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 28 1879

8. AGE: Years	Months	Days	If less than one day
65	7	21	hrs. min.

9. Birthplace Westminster Md.
(Town, county, and state)

10. Usual occupation Real estate broker

11. Industry or business

FATHER 12. Name George W. Sullivan

13. Birthplace Md.

MOTHER 14. Maiden name Luinda Miller

15. Birthplace Md.

16. Informant Mrs. Emma M. Sullivan

Address 15 Milton Ave. Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21-1945 (month) (day) (year)

Cemetery or crematory Bixler Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Sons

Address Westminster Md.

19. 1/20 1945 (Date rec'd by registrar) C. H. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 19th 1945 at 1 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1944 to January 19th 1945 and that I last saw h. alive on January 19th 1945

Immediate cause of death	DURATION
Respiratory failure	
due to Paralysis of Nerves of	3 hours.
Due to Respiration	
Due to Hypostatic Pneumonia	10 Months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore Bond M.D.
M. D. or other

Address Westminster, Md. Date signed 1/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00373

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years, 1 month
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 15 years, 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: None
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elsie Irene True

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 14, 1914

8. AGE: Years	Months	Days	If less than one day
30	4	20	..... hrs. ..... min.

9. Birthplace: Washington County, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Unk

13. Birthplace

MOTHER 14. Maiden name: Unk

15. Birthplace

16. Informant: Rev. Wm. Houck

Address: 935 Washington Boulevard, Baltimore, Maryland

17. [illegible] Date thereof: Jan. 10 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Springfield State Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Eder

Address: Sykesville, Md.

19. Jan. 10 1945 C. Harry Eder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6, 1945, at 1:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4. 1944, to Jan 6 1945

and that I last saw h..ex alive on Jan. 6 1945

Immediate cause of death	DURATION
(a) Pulmonary tuberculosis	4 mos. +
Due to:	
Due to:	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	15 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. or other

Address: Sykesville, Md. Date signed 1-8-45

00374

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 2 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 122 S. Bond St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HODGES TURNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lucille Turner
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): December 15, 1896

8. AGE: Years	Months	Days	If less than one day
48	0	29	...hrs. ...min.

9. Birthplace: Suffolk, Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Joe Turner
13. Birthplace: Suffolk, Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16th/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brookland Md
18. Funeral director: Edwin O Wilson
Address: 1000 Brantley Rd

19. Jan. 13, 19 45 (Date rec'd by registrar) Albert R. Swankhaven Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 19 45, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 19 44, to Jan. 13, 19 45
and that I last saw him alive on Jan. 13, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 1-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77-2)

00375

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? less than 24 hours
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? less than 24 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Unknown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM WALLACE WALKER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 1, 1898

8. AGE: Years	Months	Days	If less than one day
46	6	25	hrs. min.

9. Birthplace: Springfield, Kentucky
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unkn.

FATHER
12. Name: Albert Browning Walker
13. Birthplace: Springfield, Ky.

MOTHER
14. Maiden name: Martha Taylor
15. Birthplace: unkn.

16. Informant: Hospital records.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 29 1945 (month) (day) (year)
Cemetery or crematory: Springfield
Location: Springfield, Kentucky
18. Funeral director: Hale & Edelen
Address: Springfield, Kentucky

19. Jan. 26 1945 (Date rec'd by registrar) C. Harry Edelen, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1945, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1945 to January 25 1945 and that I last saw h... alive on January 25 1945

Immediate cause of death	DURATION
Acute Alcoholic Intoxication	1 week
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert, M.D. (M. D. or other)
Address: S.V. Hosp., Sykesville, Md. Date signed: 1-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00376

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: CARROLL

City or town: FINKSBURG

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: FINKSBURG

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: NONE

3.(a) FULL NAME: ELEANOR WARD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: HARVEY R. WARD

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 17, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	13	hrs. min.

9. Birthplace: CARROLL COUNTY MD. (Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER — 12. Name: GEORGE CRESS

13. Birthplace: GERMANY

MOTHER — 14. Maiden name: MARY DUTRAW

15. Birthplace: MARYLAND

16. Informant: JAMES S WARD

Address: BALTIMORE, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/45 (month) (day) (year)

Cemetery or crematory: LEISTER'S CEMETERY

Location: NEAR WESTMINSTER, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 1/31 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 19 45 at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Fracture Skull, Rt femur ext	
Comp. Fracture Left Tibia &	
Due to: fall Auto -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1/30/45

Where did injury occur? Frederick (City or town) County (State)

Injured at home, farm, industry, public place (where?): Route 140 -

Means of injury: Struck by automobile Injured at work? NO

23. SIGNATURE: James T. Monk, Deputy Medical Examiner M. D. or other

Address: New Windsor, Md. Date signed 1/30/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

T

00377

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 30 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 929 N. Mount Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ESTHER WATSON

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Alexander Watson
6.(c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.): November 25, 1923

8. AGE: Years	Months	Days	If less than one day
21	1	22	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Claybrooke Carter
13. Birthplace: Virginia

MOTHER
14. Maiden name: Minnie Nutt
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1945 (month) (day) (year)
Cemetery or crematory: Mt auburn Cem.
Location: Baltimore Md.
18. Funeral director: Metropolitan Funeral Home Inc.
Address: 927 N. mount St.

19. Jan. 16, 1945 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16, 1945, at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17, 1944, to Jan. 16, 1945 and that I last saw her alive on January 16, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	July 1940
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00378

CERTIFICATE OF DEATH

Reg. Diat. No. 3024

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 9 mo. 1 da

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 yr 9 mo 1 da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants, give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Susanna Watts

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: [redacted]

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years: 84 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at home

FATHER — 12. Name: George Lemell

13. Birthplace: Md.

MOTHER — 14. Maiden name: Manilla Berry

15. Birthplace: Md.

16. Informant: Mrs Ruth Funk

Address: 250 Fredricka Ave, Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9, 1945 (month) (day) (year)

Cemetery or crematory: Melville

Location: Elkridge, Md

18. Funeral director: Frederick A. Cole

Address: 1700 N. Longwood St

19. [illegible] (Date rec'd by registrar) 1945 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5th 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1943 to Jan 5th 1945

and that I last saw h[illegible] alive on Jan 5th 1945

Immediate cause of death: Uremia

Due to: Pulmonary Tuberculosis — DURATION: 2 mos

Due to: Chronic Myocarditis — DURATION: 20 yrs

Other conditions: Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Gaston M.D. M. D. or other

Address: Sykesville, Md. Date signed: 5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0037?

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 7 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 677 George Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sallie May Williamson

3.(b) Social Security Number: 219-05-7688

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
famale	colored	married

6.(b) Name of husband or wife: Dent Williamson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1908

8. AGE: Years	Months	Days	If less than one day
36	8	1	hrs. min.

9. Birthplace: Shelby, North Carolina (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

FATHER
12. Name: Albert Lutz
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Mary Ross
15. Birthplace: North Carolina

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Maryland.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jan. 5, 1945 (month) (day) (year)
Cemetery or crematory:
Location: King Mountain N.C.
18. Funeral director: adolphus Hollstead
Address: 918 Druid Hill ave

19. 1/3 (Date rec'd by registrar) 19 45 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3, 19 45 at 6.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov., 27 19 44, to Jan., 3, 19 45 and that I last saw her alive on January 3, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 8th 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed 1/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00380

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 2 mo., 10 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1634 E. Madison St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: DELORES ESTELLE WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21, 1932

8. AGE: Years	Months	Days	If less than one day
12	6	1	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business: at school

FATHER
12. Name: Willie Wilson
13. Birthplace: Durham, N. Carolina

MOTHER
14. Maiden name: Grace Hayes
15. Birthplace: Hopewell, Va.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation or removal): Date thereof: Jan 25-1945 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cemetery
Location: Baltimore Md
18. Funeral director: Robert E Gilbert
Address: 1515 McElderry St

19. 1/22 19 45 (Date rec'd by registrar) Albert R. Trautham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22, 19 45 at 12.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov., 12, 19 43, to Jan., 22, 19 45 and that I last saw her alive on January 22, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1938
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 1/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-B)

CERTIFICATE OF DEATH

00381

Reg. Dist. No. 24

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months, 23 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Unk

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Louis Wilt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 18, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	2	..... hrs. ..... min.

9. Birthplace: Garrett County, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Sawmill

FATHER — 12. Name: Unk

13. Birthplace

MOTHER — 14. Maiden name: Unk

15. Birthplace

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23 1945 (month) (day) (year)

Cemetery or crematory: Westernport

Location: Allegany Co. Md.

18. Funeral director: D. L. Bond

Address: Westernport, Md.

19. Jan. 22 19 45 (Date rec'd by registrar) C. Harry Wiles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 19 45, at 12:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 8 19 44 to Jan. 20 19 45

and that I last saw him alive on January 20 19 45

Immediate cause of death: General paralysis of the insane, prior to — DURATION: May '44

Due to:

Due to:

Other conditions:

(Include pregnency within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M. D. or other

Address: Sykesville, Maryland Date signed: 1-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00382

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 6 mos 23 da

Hospital, institution, or street address (if not in hospital): Springfield State Hospital

How long in hospital or institution? 4 yrs 6 mos 25 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Kisocka

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widowed

6.(b) Name of husband or wife: unknown.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-6-7

8. AGE: Years 78 | Months - | Days - | If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: unknown

13. Birthplace:

MOTHER — 14. Maiden name: unknown

15. Birthplace:

16. Informant: Anna Kunczyer

Address: 722 S Regester St Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 20 1945 (month) (day) (year)

Cemetery or crematory: Springfield State Hosp. Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Wiser

Address: Sykesville, Md.

19. Jan 20 1945 (Date rec'd by registrar) C. Harry Wiser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 13 1945 at 5 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 17 1940 to Jan 13th 1945

and that I last saw h... alive on Jan 13th 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Chr. Myocarditis.	?
Due to Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Gaston MD M. D. or other

Address: Sykesville Md. Date signed 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

00383

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 HRS.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: WESTMINSTER
(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 E. MAIN ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ALLEN WITMER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JANUARY 4, 1945

8. AGE: Years | Months | Days | If less than one day: 9 hrs. ..... min.

9. Birthplace: WESTMINSTER, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: WILLIAM R. WITMER
13. Birthplace: HAGERSTOWN, MD.

MOTHER
14. Maiden name: JUANITA A. VINSON
15. Birthplace: HAGERSTOWN, MD.

16. Informant: WILLIAM R. WITMER
Address: WESTMINSTER, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1/5/45 (month) (day) (year)

Cemetery or crematory: WESTMINSTER CEM.

Location: " MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 1/5 (Date rec'd by registrar) 19.. H. R. Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 4 19.45, at 3 P. M.

21. I CERTIFY that death occurred ~~on the date~~ above stated; that I attended deceased from January 4 19.45, to January 4 19.45

and that I last saw h.. alive on January 4 19.45

Immediate cause of death: Premature Post-Partum

Due to: severe pregnancy

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: 2 hrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Stuart Bon (M.D.)
M. D. or other

Address: Westminster Maryland Date signed: 1/4/45

Original sent to State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00384

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 928 Harlem Ave.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war:

3. (a) FULL NAME: MYRTLE WRIGHT

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Langdon Wright
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 22, 1917

8. AGE:	Years	Months	Days	If less than one day
	27	2	21	hrs. min.

8. Birthplace: Ellicott City, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Cole
13. Birthplace: Granite, Maryland

MOTHER
14. Maiden name: Virginia Smith
15. Birthplace: Cooksville, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-45 (month) (day) (year)
Cemetery or crematory: Ellicott City
Location: Ellicott City Md
18. Funeral director: J. F. Wiseburn
Address: Ellicott City Md

19. Jan. 12, 1945 (Date rec'd by registrar) Albert R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12, 1945 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4, 1944 to Jan. 12, 1945 and that I last saw her alive on January 12, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed 1-12-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

00385

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St.Mary's
City or town: Leonardtown,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS EUGENE YOUNG

3.(b) Social Security Number: Lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 9, 1921

8. AGE: Years	Months	Days	If less than one day
23	8	2	hrs. min.

9. Birthplace: Leonardtown, Md. (Town, county, and state)
10. Usual occupation: Surveyor's Helper
11. Industry or business

FATHER
12. Name: Eugene Young
13. Birthplace: Leonardtown, Md.

MOTHER
14. Maiden name: Elizabeth Trent
15. Birthplace: Leonardtown, Md.

16. Informant: Reuben Hoffman, Md.
Address: Henryton, Maryland

17. (Burial, cremation, or removal) Which? Burial Date thereof: Jan 15-45 (month) (day) (year)
Cemetery or crematory: St. Aloysius.
Location: Leonardtown, Md
18. Funeral director: H.C. Mattingley Sons
Address: Leonardtown, Md.

19. (Date rec'd by registrar) Jan. 11, 1945 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1945 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20, 1944 to Jan. 11, 1945 and that I last saw him alive on Jan. 11, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10-15-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 1-11-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15